Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Ft Worth

Respondent Name
Poly America LP

MFDR Tracking Number
M4-15-0875-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
November 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. All other claims have been paid in full for this patient. I have presented same documentation to the carrier and they are still denying. Treating provider has attached dictation for these office visits. Dr. Lopez has outlined key components during the office visits. Clearly, they are wrong and all of my documentation states otherwise. Office visits are recommended as determined to be medically necessary. Please see attached patient account statement showing all other claims being paid in a timely manner. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR. THESE ARE NOT DUPLICATES. All other claims have been paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: $278.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 18, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 5 – 19, 2014	Evaluation & Management, established patient (99213, 99214)	$278.17	$112.33

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.203 defines the medical fee guidelines for reimbursement of professional services.
3. 28 Texas Administrative Code §133.210 sets out the documentation requirements for bill submission.
4. 28 Texas Administrative Code §133.240 sets out the procedures for paying or denying medical bills.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   For date of service May 5, 2014:
   - 15 – Payer deems the information submitted does not support this level of service.

   For date of service May 19, 2014:
   - 11 – Service not furnished directly to the patient and/or not documented.
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - ZE10 – Not defined as required in 28 Texas Administrative Code §133.240.

Issues

1. Did the requestor support the level of service for CPT Code 99214 for date of service May 5, 2014 according to 28 Texas Administrative Code §133.203?
2. Was the insurance carrier's initial denial for lack of documentation for date of service May 19, 2014 appropriate?
3. Did the requestor support the disputed service for CPT Code 99213 for date of service May 19, 2014 according to 28 Texas Administrative Code §133.203?
4. What is the correct MAR for the payable services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied CPT Code 99214 on date of service May 5, 2014 stating "Payer deems the information submitted does not support this level of service." 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient.

   The American Medical Association (AMA) CPT code description for 99214 is:

   > Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: **A detailed history; A detailed examination; Medical decision making of moderate complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family [emphasis added].

   The 1995 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Required components for documentation of CPT Code 99214 are as follows:

   - Documentation of the Detailed History:
     - "An *extended* [History of Present Illness (HPI)] consists of at least four elements of the HPI."
     - "An *extended* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. [Guidelines require] the patient's positive responses and pertinent negatives for two to nine systems to be documented."
     - "A *pertinent* [Past Family, and/or Social History (PFSH)] is a review of the history area(s) directly related to the problem(s) identified in the HPI. [Guidelines require] at least one specific item from any three history areas [(past, family, or social)] must be documented…"

     The Guidelines state, "To qualify for a given type of history, **all three elements in the table must be met.**"
   - Documentation of a Detailed Examination:
     - A "*detailed examination* – an extended examination of the affected body area(s) and other symptomatic or related organ system(s)." The Guidelines state, "Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or

organ system(s) should be documented. A notation of 'abnormal' without elaboration is insufficient."

- Documentation of Decision Making of Moderate Complexity:
  - *Number of diagnoses or treatment options* – The number of problems, whether the problem is diagnosed, and types of diagnostic testing recommended are taken into account.
  - *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source.
  - *Risk of complications and/or morbidity or mortality* – "The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines overall risk."

"To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**."

Review of the documentation for this date of service supports that the requestor provided a review of six (6) elements of HPI, a review of symptoms for two (2) systems, and no PFSH. This does not meet the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of a limited examination of the affected organ system and related organ systems for a total of two (2) systems. This does not meet the criteria for a Detailed Examination. The submitted documentation supports that the requestor met the criteria for documentation of Decision Making of Low Complexity. **Because the documentation indicates that the requestor did not meet any of the required key components of CPT Code 99214, the requestor did not support this level of service.**

2. The insurance carrier denied CPT Code 99213 for date of service May 19, 2014, stating "Service not furnished directly to the patient and/or not documented," in the initial denial, and "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication" on reconsideration.

   Documentation requirements are established by 28 Texas Administrative Code §133.210 which describes the documentation required to be submitted with a medical bill. 28 Texas Administrative Code §133.210 does not require documentation to be submitted with the medical bill for the services in dispute.

   Further, the process for a carrier's request of documentation not otherwise required by 28 Texas Administrative Code §133.210 is described in section (d) of that section as follows:

   "Any request by the insurance carrier for additional documentation to process a medical bill shall:
   (1) be in writing;
   (2) be specific to the bill or the bill's related episode of care;
   (3) describe with specificity the clinical and other information to be included in the response;
   (4) be relevant and necessary for the resolution of the bill;
   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   (6) indicate the specific reason for which the insurance carrier is requesting the information; and
   (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation."

   No documentation was found to support that the carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The Division concludes that carrier failed to meet the requirements of 28 Texas Administrative Code 133.210(d). The carrier's denial for this reason is not appropriate.

3. The American Medical Association (AMA) CPT code description for 99213 is:

   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: **An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity.** Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family [emphasis added].

   The 1995 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Required components for documentation of CPT Code 99213 are as follows:

   - Documentation of the Expanded Problem Focused History:
     - "A *brief* [History of Present Illness (HPI)] consists of at least one to three elements of the HPI."
     - "A *problem pertinent* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI. [Guidelines require] the patient's positive responses and

pertinent negatives for the system related to the problem should be documented."

- No Past Family, and/or Social History (PFSH) is required at this level of service.

The Guidelines state, "To qualify for a given type of history, **all three elements in the table must be met.**"

- Documentation of an Expanded Problem Focused Examination:
  - An "*expanded problem focused examination* – a limited examination of the affected body area or organ system and other symptomatic or related organ system(s)." The Guidelines state, "Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of 'abnormal' without elaboration is insufficient."
- Documentation of Decision Making of Low Complexity:
  - *Number of diagnoses or treatment options* – The number of problems, whether the problem is diagnosed, and types of diagnostic testing recommended are taken into account.
  - *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source.
  - *Risk of complications and/or morbidity or mortality* – "The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines overall risk."

"To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**."

Review of the documentation for this date of service supports that the requestor provided a review of five (5) elements of HPI, a review of symptoms for one (1) system, and no PFSH. This meets the documentation requirements for an Expanded Problem Focused History. The submitted report shows that the requestor included performance and documentation of a limited examination of the affected body area. This does not meet the criteria for an Expanded Problem Focused Examination. The submitted documentation supports that the requestor met the criteria for documentation of Decision Making of Low Complexity. **Because the documentation indicates that the requestor met at least two (2) of the required key components of CPT Code 99213, the requestor's documentation did support this service.**

4. Procedure code 99214, service date May 5, 2014 is not payable per the documentation above.

   Payable procedure code 99213, service date May 19, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.002 is 0.97194. The practice expense (PE) RVU of 1 multiplied by the PE GPCI of 0.987 is 0.987. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.799 is 0.05593. The sum of 2.01487 is multiplied by the Division conversion factor of $55.75 for a MAR of $112.33.
5. The total allowable for the disputed services is $112.33. The insurance carrier paid $0.00. Therefore, a reimbursement of $112.33 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $112.33.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $112.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	April 7, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.